Definition:

Shared decision making is when health professionals and patients work together. It places equal worth on the values and preferences of the patient and expert knowledge of the health care professional.

People are:

- Supported to understand care and treatment options as well as what is known of benefits, harms and consequences of those options.

- Supported to make a decision about a preferred course of action, based on evidence, good quality information and their personal preferences.

Clinical Scenario:

Mr Jay is a 58 year old taxi driver who has hypertension which is well-controlled. He rarely comes to the surgery except for annual reviews. On his recent blood test, it is noted that he has pre-diabetes and he is invited to the surgery to discuss this.

Mr Jay lives with his wife and has a young granddaughter whom he looks after. Through your discussions with Mr Jay, you discover that it is very important to him to manage any conditions he has well due to his sense of responsibility for his granddaughter. After an initial conversation about pre-diabetes, you discuss the potential options for management.

Due to his work schedule, Mr Jay does not think he will be able to attend any face to face courses. However, he tells you that he is quite comfortable with the use of technology and apps. You give him information about some apps focused on pre-diabetes and he decides to explore this and choose one to use to assist him in making some lifestyle changes.
RCPG Universal Personalised Care Definitions and Standards

**Definition:**

People living with long term conditions or disability and their carers/family have a **proactive, personalised conversation** which focuses on what matters to them. The purpose of the conversation is to support them to keep well and to live independently.

It is an ongoing and dynamic process and pays attention to people’s wider health and wellbeing as well as their clinical needs.

**Clinical Scenario:**

Mrs. Roy is a 72 year old lady who has chronic obstructive pulmonary disease (COPD), diabetes and an overactive bladder. She has had four short admissions to hospital this year for exacerbations of COPD. Through a personalised care plan conversation Mrs. Roy’s goals and support needs are identified. She explains that she does not feel confident using her rescue medications. Often, she feels very anxious about her breathing and isn’t sure whether she needs to call 999 or not.

It is agreed that her goal is to walk to the local shops as it is important to her to remain as independent as possible. She is given information about her local Breathe Easy group. She also works with her primary care teams to develop a self-management plan for her COPD in order to understand what she can do to prevent exacerbations, when and how to use rescue medications, and when to seek emergency care and who to contact. A plan is made to review Mrs. Roy’s progress in 6 months.

**Standards: What does this look like in practice?**

**IMPLEMENTING**

- Individuals are central to the personalised care and support planning process and agree on who is involved.

**STANDARD**

- People are prepared and know what to expect through the process.

**IMPLEMENTING**

- Individuals have the time and support for conversations and to develop their plan in a safe and reflective space.

**IMPLEMENTING**

- Individuals work together with care practitioners to discuss what matters to them and what they want to achieve, identifying objectives that are personal to them as well as meeting their

**IMPLEMENTING**

- Individuals and healthcare professionals have the opportunity to reflect on and amend care plans – PCSP is a continuous and dynamic process.
**RCGP Universal Personalised Care Definitions and Standards**

**Definition:** Enables choice of provider and services that better meet people’s needs.

This includes individual’s legal rights to choose in respect of first outpatient appointments, and suitable alternative provider if people are not able to access certain services within the national waiting time standards.

**Clinical Scenario:**

Mr Bhat is a 72 year old man with right knee osteoarthritis. He is due to have a knee replacement due to effect of his symptoms on his daily activities. His local hospital is within easy reach but has a longer waiting list. He is informed that next nearest hospital has a shorter waiting list and he is offered the choice of having the operation there.

After being provided with the information available on his options Mr Bhat opts to have the operation at his local hospital as he feels he will be less anxious due to familiarity with the environment. It is also important to him for his wife to be able to visit easily.

**Standards: What does this look like in practice?**

<table>
<thead>
<tr>
<th>IMPLEMENTING</th>
<th>STANDARD</th>
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</thead>
<tbody>
<tr>
<td>Information on patients’ legal rights to choice is accessible, publicised and promoted, taking into account health literacy.</td>
<td>✓</td>
</tr>
<tr>
<td>Patients are supported to understand the choices available and be able to make an informed decision.</td>
<td>✓</td>
</tr>
<tr>
<td>There are regular reviews to understand how choice is benefiting patients and to consider extending choice beyond the established legal rights, where patients would benefit.</td>
<td>✓</td>
</tr>
</tbody>
</table>
**RCGP Universal Personalised Care Definitions and Standards**

**Definition:**

A whole-system strategy which makes the most of community and informal support.

Includes enabling all local agencies to refer people to a ‘link worker’ to connect them into a variety of holistic, local, clinical and non-clinical community-based support.

**Social prescribing** builds on the conversation of what matters to the person as identified through shared decision making and personalised care and support planning.

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## Standards: What does this look like in practice?

<table>
<thead>
<tr>
<th>IMPLEMENTING</th>
<th>STANDARD</th>
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<tbody>
<tr>
<td>Social prescribing builds on a conversation about what matters to the person as identified through shared decision making and / or personalised care and support planning.</td>
<td>✓</td>
</tr>
<tr>
<td>Social prescribing enables health professionals to refer patients to link workers or a social prescriber.</td>
<td>✓</td>
</tr>
<tr>
<td>People have a conversation with the link worker during which they can learn about opportunities to improve their health and wellbeing.</td>
<td>✓</td>
</tr>
<tr>
<td>People with social, emotional or practical needs are empowered to find and design their own personal solutions, often using services provided by the voluntary and community sector.</td>
<td>✓</td>
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**Clinical Scenario:**

Mrs. Green is a 58 year old woman with a history of breast cancer diagnosed 2 years ago. She felt unable to return to work as a teacher after treatment and now has become more isolated. She is less active than previously and spends more time indoors.

Mrs. Green finds it very helpful speaking to a friend with a history of breast cancer about her experiences. After asking Mrs. Green what was important to her, she identified that she would like to help others going through challenging times with breast cancer and to be more physically active.

Mrs. Green was given information about the local Macmillan Social Prescribing Service. She became involved in a local walking group as a result and made new friends who could both give and receive support from her. She also collaborated with the patient participation group at her GP surgery to set up a coffee morning for individuals who have been affected by a cancer diagnosis.
**RCGP Universal Personalised Care Definitions and Standards**

**Definition:**

Supported self management acknowledges, harnesses and helps develop the knowledge, skills and confidence a person has in managing their own health and care. It includes putting in place interventions such as health coaching, self-management education, social prescribing and peer support.

**Standards: What does this look like in practice?**

<table>
<thead>
<tr>
<th>Standard</th>
<th>IMPLEMENTING</th>
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</thead>
<tbody>
<tr>
<td>Individuals are facilitated to think about their strengths and abilities and the changes they can make in their lives to take control, reach their goals and maintain their health and wellbeing.</td>
<td>✓</td>
<td></td>
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<tr>
<td>Tools such as the Patient Activation Measure (PAM) or equivalent are used to understand a person’s level of knowledge, skills and confidence. Understanding activation levels can help patients and clinicians to determine the realistic ‘next steps’ for individuals to take in terms of self-management.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Interventions such as health coaching, self-management education, peer support and social prescribing are focused on, though not limited to, those with low activation to build knowledge, skills and confidence, and take account of any inequalities and accessibility barriers.</td>
<td>✓</td>
<td></td>
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</table>

**Clinical Scenario:**

Mr Tan is a 38 year old man living with a moderate learning difficulty. He is obese and has pre-diabetes. He lives with his mother and is not employed. Mr Tan is currently taking medication for anxiety and depression.

Mr Tan enjoys walking although he finds it difficult to get out on his own due to feeling anxious. Through social prescribing, he started attending art therapy classes with other people who have learning difficulties. Over time, he found the consistent support and friendly relationships helped him feel more confident about going out. After a care planning conversation, he also downloaded a pedometer app. Mr Tan started to walk more regularly, aiming to better the number of steps walked previously.

As a result, Mr Tan found it is easier to be active every day and lose weight, thereby managing his pre-diabetes through lifestyle changes.
An amount of money to support a person’s identified health and well-being needs, planned and agreed between them and their local NHS team. 

Health professional work collaboratively with PHB recipients to ensure budgets are spent on evidence-based approaches to care and support.

This isn’t new money, but a reallocation – a different way of spending health and care funding to meet the needs of an individual.

**Clinical Scenario:**

Mrs. Goel is a 82 year old lady with Alzheimer’s disease which was diagnosed 10 years ago. Gradually, she has become more frail and frequently struggles to manage at home. Mrs. Goel requires frequent stays in residential homes to support her declining health.

Her wish was to remain at home with her daughter rather than in a residential or nursing home towards the end of her life. Each move to a residential home adds to the unease of Mrs. Goel and her daughter. Following a shared decision making conversation and creation of a care plan, she received a PHB and lives with her daughter. The PHB allows Mrs. Goel’s daughter to pay for a team of seven personal assistants who provide consistent care.

Mrs. Goel has not required any emergency admissions to residential or nursing home care. In addition, she has not needed any hospital admissions thereby avoiding traumatic upheavals.